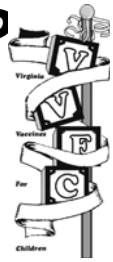
VACCINE ADMINISTRATION AND SCREENING RECORD



Patient Name: _____

Date of Birth: _____

Medical Chart Number: _____

Physician: _____

Practice Address:

VACCINE Administered (Please circle when choices are given)	**Admin. Date (M/D/Y)**	**VVFC Eligibility Screening* (use key)**	**Vaccine Manufacturer**	**Vaccine Lot Number**	**Site** (Optional)	**Expiration Date (M/D/Y)** (Optional)	**Vaccine Admin's Initials**	**VIS Pub. Date**	**Parent or Guardian Initials** (Optional)
DT / DTaP 1									
DT / DTaP 2									
DT / DTaP 3									
DT / DTaP 4									
DT / DTaP 5									
Hib 1									
Hib 2									
Hib 3									
Hib 4									
Hep A 1									
Hep A 2									
Hep B 1									
Hep B 2									
Hep B 3									
Influenza 1									
Influenza 2									
IPV 1									
IPV 2									
IPV 3									
IPV 4									
Meningococcal									
MMR 1									
MMR 2									
Pneumococcal 1									
Pneumococcal 2									
Pneumococcal 3									
Pneumococcal 4									
Rotavirus 1									
Rotavirus 2									
Rotavirus 3									
Varicella 1									
Varicella 2									
Tdap									
Td									

Combination vaccines should be documented under each antigen.

*VVFC ELIGIBILITY SCREENING

Patients must be screened each visit prior to vaccination.
Use VFC vaccine on eligible patients only.

VVFC eligible because they are <19 y/o and,

M = Child has Medicaid or Medicaid HMO

U = Child is Uninsured

A = Child is American Indian or Alaskan Native

Not VVFC eligible and received private vaccine,

P = Child has Private Insurance

SIGNATURE OF VACCINE ADMINISTRATOR(S)

_____

Name Title

_____

Name Title

_____

Name Title

If more lines are necessary, please use the back.

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